

Indiana State Department of Health
State Form 49684 (R2/1-05)

1 Print firmly and neatly. **3** Fill in circles like this: ● **4** Print capital letters only and numbers completely inside boxes. **5** Please complete all items on form. **6** Date format: MM/DD/YY

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THIS FORM CONTAINS CONFIDENTIAL INFORMATION PER 410 IAC 1-2.3

BOTULISM CASE INVESTIGATION - Page 2 of 5

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Section 2. Clinical Information (continued)

Physician/Hospital that Collected Specimen

Physician/Hospital Address

City State ZIP Code

Physician/Hospital Phone

Was testing performed on CSF? ☐ Yes ☐ No ☐ Unknown

If Yes, results

Was CAT scan performed? ☐ Yes ☐ No ☐ Unknown

If Yes, results

Was a tensilon test performed? ☐ Yes ☐ No ☐ Unknown

If Yes, results

Was electromyography performed? ☐ Yes ☐ No ☐ Unknown

If Yes, results

Was the patient treated with
antitoxin for this illness?

☐ Yes ☐ No

If Yes, manufacturer: _____

Dosage: _____

Was the patient hospitalized?

☐ Yes ☐ No

If Yes, admission date: ____/____/____

Discharge date: ____/____/____

Hospital: _____

Did patient die?

☐ Yes ☐ No

Section 3. Epidemiologic Information

List all commercial food establishments serving ready-to-eat food that the patient patronized during the 5 days prior to illness onset.

1. _____
Establishment Name

Address

Foods Eaten (list) Date ____/____/____

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Section 3. Epidemiologic Information (continued)

2.
Establishment Name

Address

/ /
Foods Eaten (list) Date

3.
Establishment Name

Address

/ /
Foods Eaten (list) Date

4.
Establishment Name

Address

/ /
Foods Eaten (list) Date

List all group gatherings where food was served that the patient attended during the 5 days prior to illness onset.

1.
Type of Gathering

Responsible Person

- - / /
Phone Number No. of Persons Date

2.
Type of Gathering

Responsible Person

- - / /
Phone Number No. of Persons Date

List all stores where the patient bought groceries that were consumed during the 5 days prior to illness onset.

Store Name:	Street Address:	Date:
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

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Indicate whether the patient consumed the following foods or beverages during the 5 days prior to illness onset.

[illegible]

During the 5 days prior to illness onset, did the patient:

Eat any foods (leftovers) sitting out several days? ☐ Yes ☐ No ☐ Unknown

A horizontal number line with 21 tick marks, labeled from 0 to 20. The line is used for plotting the data points from the frequency table.

Eat any "natural" foods or "health" foods? ☐ Yes ☐ No ☐ Unknown

Eat any ethnic foods? ☐ Yes ☐ No ☐ Unknown

Eat any foods with a foul taste or odor? ☐ Yes ☐ No ☐ Unknown

Eat any foods from swollen containers? ☐ Yes ☐ No ☐ Unknown

Where prepared

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Section 4. Risk Factors (continued)

During the 5 days prior to illness onset, did the patient:

Drink any homemade alcoholic beverages? ☐ Yes ☐ No ☐ Unknown

If Yes, which beverage

Where prepared

Travel outside of Indiana? ☐ Yes ☐ No ☐ Unknown

If Yes, where

____/____/____ ____/____/____

Date of departure

Date of return

Does the patient know anyone else who has recently had an illness characterized by diarrhea, fever, or abdominal pain? ☐ Yes ☐ No ☐ Unknown

If Yes, name

Relationship

____ - ____ - ____ ____/____/____

Phone number

Onset date

Was this person exposed to any of the same commercial food establishments, group gatherings, or travel history listed above? ☐ Yes ☐ No ☐ Unknown

If Yes, describe

During the 14 days prior to illness onset, did the patient:

Sustain any cut or wound? ☐ Yes ☐ No ☐ Unknown

If Yes, describe

Use needles for the injection of illegal drugs? ☐ Yes ☐ No ☐ Unknown

If Yes, describe

Section 5. Comments/Follow-up

Comments:

Investigator Name

Agency

____ - ____ - ____ ____/____/____

Phone Number

Date